General

Guideline Title

British Association of Dermatologists' guidelines for the management of alopecia areata 2012.

Bibliographic Source(s)

Messenger AG, McKillop J, Farrant P, McDonagh AJ, Sladden M. British Association of Dermatologists' guidelines for the management of alopecia areata 2012. Br J Dermatol. 2012 May;166(5):916-26. [92 references] PubMed

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: MacDonald Hull SP, Wood ML, Hutchinson PE, Sladden M, Messenger AG. Guidelines for the management of alopecia areata. Br J Dermatol 2003 Oct;149(4):692-9.

Recommendations

Major Recommendations

Definitions for the levels of evidence (1++, 1+, 1-, 2++, 2+, 2-, 3, 4) and strength of recommendations (A-D) are presented at the end of the "Major Recommendations" field.

Diagnosis

The diagnosis of alopecia areata is usually straightforward although the following may cause diagnostic difficulties:

1. Trichotillomania: This condition probably causes most confusion and it is possible that it coexists with alopecia areata in some cases. The incomplete nature of the hair loss in trichotillomania and the fact that the broken hairs are firmly anchored in the scalp (i.e., they remain in the growing phase, anagen, unlike exclamation mark hairs) are distinguishing features.
2. Tinea capitis: The scalp is inflamed in tinea capitis and there is often scaling but the signs may be subtle.
3. Early scarring alopecia
4. Telogen effluvium
5. Anagen effluvium (drug-induced) may mimic diffuse alopecia areata
6. Systemic lupus erythematosus
7. Secondary syphilis

Dermoscopy can aid the diagnosis of alopecia areata. Regular round yellow dots are commonly seen in areas of hair loss and can indicate active disease progression. Dermoscopy also highlights common features seen in this condition such as dystrophic hairs with fractured tips (exclamation mark hairs) and hairs fractured before emergence from the scalp (cadaverized hairs). These findings are not present in triangular alopecia,

trichotillomania or localized scarring conditions, which are sometimes considered within the differential of alopecia areata. Occasionally, alopecia areata presents as diffuse hair loss which can be difficult to diagnose. The clinical course often reveals the true diagnosis but a biopsy may be necessary in some cases.

Investigations

Investigations are unnecessary in most cases of alopecia areata. When the diagnosis is in doubt appropriate tests may include fungal culture, skin biopsy, serology for lupus erythematosus, or serology for syphilis. The increased frequency of autoimmune disease in patients with alopecia areata is probably insufficient to justify routine screening.

One small case series suggested that iron deficiency is more common in women with alopecia areata than the population at large but this was not confirmed in two subsequent studies, and routine testing for iron status is not recommended. There are no published studies demonstrating a treatment response to iron replacement therapy.

Management

An overriding consideration in the management of alopecia areata is that, although the disease may have a serious psychological effect, it has no direct impact on general health that justifies the use of hazardous treatments, particularly of unproven efficacy. In addition, many patients, although by no means all, experience spontaneous regrowth of hair. However, the psychological effects of alopecia may impact on general health and depends on the individual's coping strategy when dealing with an altered body image, which can result in higher levels of anxiety and a greater risk of depression leading to social, work-related and personal problems.

Counselling

An explanation of alopecia areata, including discussion of the nature and course of the disease and the available treatments, is essential. Some patients are profoundly upset by their alopecia and may require psychological support. Many find it difficult to disclose their alopecia to family members and friends and struggle to find the answers to their medical and many practical questions. Contact with other patient experts and patient support groups can help individuals cope with the changing aspects of alopecia and provide support to find a new level of self-acceptance of their altered body image.

Alopecia areata in children can be particularly difficult. If a parent feels there is a significant change in a child's needs (withdrawn, low self-esteem, failing to achieve at school, change in behaviour), referral to a paediatric clinical psychologist, educational psychologist or social worker may be needed.

It is important to consider both the positive and negative aspects of active treatment in this chronic condition. Some patients do respond well to treatment. However, treatment can be uncomfortable for the patient, time-consuming and can be associated with undesirable side-effects. It may also alter the patient's attitude to their hair loss. Some patients find it difficult to cope with relapse following or during initially successful treatment and they should be forewarned of this possibility. These considerations are particularly important in children where the social disruption and focusing of the child's attention on their hair loss, which may result from active treatment, have to be carefully weighed against the potential benefits. On the other hand, some patients are appreciative that something has been tried, even if it does not work.

An individual's reaction to alopecia will vary depending on their own perceptions of body image, self-esteem, coping strategies, personality traits and their social support network. Commonly, people may feel self-conscious, conspicuous, angry, rejected, embarrassed or different and they may behave in a shy, cautious, aggressive, retreating, evasive or defensive (SCARED) manner. It is important to mention self- acceptance particularly in those with long-standing, extensive and persistent alopecia areata.

Summary of Treatment Recommendations

Alopecia areata is difficult to treat and few treatments have been assessed in randomized controlled trials. The tendency to spontaneous remission and the lack of adverse effects on general health are important considerations in management, and not treating is the best option in many cases. On the other hand, alopecia areata may cause considerable psychological and social disability and in some cases, particularly those seen in secondary care, it may be a chronic and persistent disease causing extensive or universal hair loss. In those cases where treatment is appropriate there is reasonable evidence to support the following:

Limited Patchy Hair Loss

- Potent topical steroid (Strength of Recommendation C)
- Intralesional corticosteroid (Strength of Recommendation C)

Treatment with potent topical corticosteroids probably advances regrowth of hair in some patients with mild to moderate disease but there are no

data on long-term outcomes. Intralesional corticosteroids stimulate hair regrowth at the site of injection. The effect is temporary, lasting a few months, and it is unknown whether the long-term outcome is influenced.

Extensive Patchy Hair Loss

- Contact immunotherapy (Strength of Recommendation C)
- Wig/hairpiece (Strength of Recommendation D)

Alopecia Totalis/Universalis(AT/AU)

- Contact immunotherapy (Strength of Recommendation C).
- Wig (Strength of Recommendation D)

Contact immunotherapy is the best-documented treatment in severe alopecia areata but it is not widely available, involves multiple visits to hospital over several months and stimulates cosmetically worthwhile hair regrowth in <50% of patients. It is the only treatment likely to be effective in AT/AU, although the response rate is low. It may cause troublesome temporary local inflammation but serious side-effects are rare.

Dithranol (anthralin) and minoxidil lotion are widely prescribed by dermatologists for limited patchy alopecia areata, and are safe, but there is no convincing evidence that they are effective.

Continuous or pulsed systemic corticosteroids and psoralen plus ultraviolet A (PUVA) have also been used to treat alopecia areata. However, in view of the potentially serious side-effects and inadequate evidence of efficacy, none can be recommended at this time.

Children may be treated in a similar fashion to adults. However, intralesional steroids are often poorly tolerated and many clinicians are reluctant to use aggressive treatments such as contact immunotherapy in children.

Definitions:

Levels of Evidence

Level of Evidence	Type of Evidence
1++	High-quality meta-analyses, systematic reviews of randomized controlled trials (RCTs), or RCTs with a very low risk of bias
1+	Well-conducted meta-analyses, systematic reviews of RCTs, or RCTs with a low risk of bias
1-	Meta-analyses, systematic reviews of RCTs, or RCTs with a high risk of bias*
2++	High-quality systematic reviews of case–control or cohort studies High-quality case–control or cohort studies with a very low risk of confounding, bias or chance and a high probability that the relationship is causal
2+	Well-conducted case–control or cohort studies with a low risk of confounding, bias or chance and a moderate probability that the relationship is causal
2-	Case–control or cohort studies with a high risk of confounding, bias or chance and a significant risk that the relationship is not causal*
3	Nonanalytical studies (for example, case reports, case series)
4	Expert opinion, formal consensus

*Studies with a level of evidence '-' should not be used as a basis for making a recommendation.

Strength of Recommendation

Class	Evidence
A	• At least one meta-analysis, systematic review, or randomized controlled trial (RCT) rated as 1++, and directly applicable to the target population or • A systematic review of RCTs or a body of evidence consisting principally of studies rated as 1+, directly applicable to the target population, and demonstrating overall consistency of results or • Evidence drawn from a National Institute for Health and Clinical Excellence (NICE) technology appraisal

Class	Evidence
	• A body of evidence including studies rated as 2++, directly applicable to the target population, and demonstrating overall consistency of results, or • Extrapolated evidence from studies rated as 1++ or 1+
C	• A body of evidence including studies rated as 2+, directly applicable to the target population and demonstrating overall consistency of results, or • Extrapolated evidence from studies rated as 2++
D	• Evidence level 3 or 4, or • Extrapolated evidence from studies rated as 2+ or • Formal consensus
D (GPP)	• A good practice point is a recommendation for best practice based on the experience of the guideline development group

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

Alopecia areata

Guideline Category

Counseling

Diagnosis

Management

Treatment

Clinical Specialty

Dermatology

Family Practice

Internal Medicine

Pediatrics

Intended Users

Advanced Practice Nurses

Physician Assistants

Physicians

Guideline Objective(s)

To provide up-to-date recommendations for the management of alopecia areata in adults and children and a summary of the evidence base

Target Population

Adults and children with alopecia areata

Interventions and Practices Considered

Diagnosis

1. Differential diagnosis
2. Dermoscopy
3. Appropriate tests when diagnosis is in doubt: fungal culture, skin biopsy, serology for lupus erythematosus, serology for syphilis

Treatment/Management

1. No treatment
2. Topical corticosteroids (e.g., clobetasol propionate)
3. Intralesional corticosteroids (e.g., triamcinolone acetonide)
4. Contact immunotherapy (contact allergen normally used is 2,3-diphenylcyclopropenone [DPCP])
5. Counselling
6. Use of wigs

Note: The following were considered but not recommended: systemic corticosteroids, photochemotherapy, minoxidil, dithranol, ciclosporin, prostaglandin F2α analogues, biologic drugs, sulfasalazine, methotrexate, isoprinosine, laser therapy, aroma therapy, hypnotherapy.

Major Outcomes Considered

- Hair regrowth
- Remission rate
- Side effects of treatments

Methodology

Methods Used to Collect/Select the Evidence

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

PubMed, MEDLINE and EMBASE databases were searched from January 2002 to January 2012 and full relevant papers in the English language obtained. Additional, targeted searches were also carried out across these three databases, as well as a search on the Allied and Complementary Medicine Database (AMED); details of the literature search strategy are available as an Appendix (see the "Availability of Companion Documents" field).

Number of Source Documents

Not stated

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Levels of Evidence

Level of Evidence	Type of Evidence
1++	High-quality meta-analyses, systematic reviews of randomized controlled trials (RCTs), or RCTs with a very low risk of bias
1+	Well-conducted meta-analyses, systematic reviews of RCTs, or RCTs with a low risk of bias
1-	Meta-analyses, systematic reviews of RCTs, or RCTs with a high risk of bias*
2++	High-quality systematic reviews of case–control or cohort studies High-quality case–control or cohort studies with a very low risk of confounding, bias or chance and a high probability that the relationship is causal
2+	Well-conducted case–control or cohort studies with a low risk of confounding, bias or chance and a moderate probability that the relationship is causal
2-	Case–control or cohort studies with a high risk of confounding, bias or chance and a significant risk that the relationship is not causal*
3	Nonanalytical studies (for example, case reports, case series)
4	Expert opinion, formal consensus

*Studies with a level of evidence '-' should not be used as a basis for making a recommendation.

Methods Used to Analyze the Evidence

Systematic Review

Description of the Methods Used to Analyze the Evidence

Not stated

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

These guidelines have been developed using the British Association of Dermatologists' recommendations and also with reference to the Appraisal of Guidelines Research and Evaluation (AGREE) instrument.

The recommendations made are those that are currently considered best practice. Where possible they are based on randomized controlled trials (RCTs). However, in view of the limited evidence from RCTs, guidance is also based on less rigorously controlled studies, uncontrolled studies, on clinical experience, and on patient experience.

Rating Scheme for the Strength of the Recommendations

Strength of Recommendation

Class	Evidence
A	• At least one meta-analysis, systematic review, or randomized controlled trial (RCT) rated as 1++, and directly applicable to the target population or • A systematic review of RCTs or a body of evidence consisting principally of studies rated as 1+, directly applicable to the target population, and demonstrating overall consistency of results or • Evidence drawn from a National Institute for Health and Clinical Excellence (NICE) technology appraisal
B	• A body of evidence including studies rated as 2++, directly applicable to the target population, and demonstrating overall consistency of results, or • Extrapolated evidence from studies rated as 1++ or 1+
C	• A body of evidence including studies rated as 2+, directly applicable to the target population and demonstrating overall consistency of results, or • Extrapolated evidence from studies rated as 2++
D	• Evidence level 3 or 4, or • Extrapolated evidence from studies rated as 2+ or • Formal consensus
D (GPP)	• A good practice point is a recommendation for best practice based on the experience of the guideline development group

Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

This guidance has been written by dermatologists and a patient representative. The draft guideline was made available for consultation and review by the British Association of Dermatologists (BAD) membership, the Primary Care Dermatological Society (PCDS), the British Dermatological Nursing Group (BDNG) and the board of Alopecia UK, a patient support organization. The final document was peer-reviewed by the Clinical Standards Unit of the BAD (made up of the Therapy and Guidelines subcommittee) prior to publication.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for each treatment recommendation (see the "Major Recommendations" field).

Where possible the recommendations are based on randomized controlled trials (RCTs). However, in view of the limited evidence from RCTs, guidance is also based on less rigorously controlled studies, uncontrolled studies, on clinical experience, and on patient experience.

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Consistent quality of care for patients with alopecia areata

Potential Harms

Topical Corticosteroids

Folliculitis is a common side-effect of treatment with potent topical steroids.

Intralesional Corticosteroids

- Patient discomfort during injection
- Skin atrophy at the site of injection is a consistent side-effect of intralesional steroid therapy, particularly if triamcinolone is used but this usually resolves after a few months.
- There is a risk of cataract and raised intraocular pressure if intralesional corticosteroids are used close to the eye (e.g., for treating eyebrows).
- There are two case reports of anaphylaxis in patients receiving intralesional triamcinolone acetonide for treatment of alopecia areata.

Contact Immunotherapy

- Most patients will develop occipital and/or cervical lymphadenopathy during contact immunotherapy. This is usually temporary but may persist throughout the treatment period. Severe dermatitis is the most common adverse effect but the risk can be minimized by careful titration of the concentration. Uncommon adverse effects include urticaria, which may be severe, and vitiligo. Cosmetically disabling pigmentary complications, both hyper- and hypopigmentation (including vitiligo), may occur if contact immunotherapy is used in patients with pigmented skin.
- Great care must be taken to avoid contact with the allergen by handlers, including pharmacy, medical and nursing staff, and other members of the patient's family. Those applying the allergen should wear gloves and aprons.

Contraindications

Contraindications

There are no data on the safety of contact immunotherapy during pregnancy and it should not be used in pregnant women or in women intending to become pregnant.

Qualifying Statements

Qualifying Statements

This document has been prepared on behalf of the British Association of Dermatologists (BAD) and is based on the best data available when the document was prepared. It is recognized that under certain conditions it may be necessary to deviate from the guidelines, and that the results of future studies may require some of the recommendations herein to be changed. Failure to adhere to these guidelines should not necessarily be considered negligent, nor should adherence to these recommendations constitute a defence against a claim of negligence.

Implementation of the Guideline

Description of Implementation Strategy

An implementation strategy was not provided.

Implementation Tools

Audit Criteria/Indicators

Patient Resources

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better

Living with Illness

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

Messenger AG, McKillop J, Farrant P, McDonagh AJ, Sladden M. British Association of Dermatologists' guidelines for the management of alopecia areata 2012. Br J Dermatol. 2012 May;166(5):916-26. [92 references] PubMed

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2003 Oct (revised 2012 May)

Guideline Developer(s)

British Association of Dermatologists - Medical Specialty Society

Source(s) of Funding

British Association of Dermatologists

Guideline Committee

British Association of Dermatologists Therapy and Guidelines Subcommittee

Composition of Group That Authored the Guideline

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Financial Disclosures/Conflicts of Interest

None of the authors has a financial or commercial interest in any of the treatments discussed. A.G. Messenger occasionally acts as a consultant to pharmaceutical companies who manufacture and market products for the treatment of hair loss disorders.

Guideline Status

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This guideline updates a previous version: MacDonald Hull SP, Wood ML, Hutchinson PE, Sladden M, Messenger AG. Guidelines for the management of alopecia areata. Br J Dermatol 2003 Oct;149(4):692-9.

Guideline Availability

Electronic copies: Available in Portable Document Format (PDF) from the British Association of Dermatologists Web site .

Availability of Companion Documents

The following is available:

- Bell HK, Ormerod AD. Writing a British Association of Dermatologists' clinical guideline: an update on the process and guidance for authors. Br J Dermatol 2009;160:725–8. Electronic copies: Available in Portable Document Format (PDF) from the British Association of Dermatologists Web site .

Literature search strategies are available on the British Journal of Dermatology Web site .

In addition, recommended audit points are provided in section 10 of the original guideline document .

Patient Resources

The following is available:

- Alopecia areata. Patient information leaflet. London (England): British Association of Dermatologists; 2010 May. 5 p. Electronic copies: Available in Portable Document Format (PDF) from the British Association of Dermatologists Web site .

NGC Status

This NGC summary was completed by ECRI on April 20, 2005. The information was verified by the guideline developer on June 27, 2005. This NGC summary was updated by ECRI Institute on August 27, 2012. The updated information was verified by the guideline developer on October 12, 2012.

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